

Improving access to sexual violence support for marginalised individuals: findings from the LGBT and BME communities

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Critical and Radical Social Work

Improving access to sexual violence support for marginalised individuals: findings from the LGBT and BME communities --Manuscript Draft--

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Abstract:	<p>Statistics suggest that survivors of sexual violence from BME and LGBT communities are less likely to access specialist support than other members of the general population. This paper highlights specific barriers these communities face in accessing support services and how they could be addressed by these services, using data from a case study conducted in the city of Brighton and Hove, UK. It also takes the original step of comparing questionnaire and interview data from survivors with questionnaire and interview data from practitioners working with the BME and LGBT communities. Recommendations are identified for sexual violence services and social workers working with these survivors that are missing from existing literature. These include a critique of the empowerment discourse commonly employed by support services, use of intersectional feminist theory to inform practice, and recommendations for 'community-embedded' support services.</p>	
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Introduction

Worldwide, an estimated 1 in 4 women and 1 in 10 men have experienced sexual violence in their lifetime (World Health Organisation, 2013; Holmes & Slap, 1998). Whilst anyone can experience sexual violence, research suggests that individuals from Black Minority Ethnic (BME¹) communities and Lesbian, Gay, Bisexual and Trans* (LGBT²) communities may be at additional risk of sexual violence, yet they are also less likely to access support than the general population (Centre for Disease Control and Prevention, 2010; Grant, Mottet & Tanis, 2011; Bubar, 2010; Thiara, Roy & Ng, 2015). The term ‘sexual violence’ is used throughout this paper to refer to acts including, but not limited to, sexual harassment, unwanted sexual touching, rape and sexual assault.

For example, nearly 1 in 2 bisexual women have experienced rape in their lifetime, compared to 1 in 6 heterosexual women (Centre for Disease Control and Prevention, 2010). More than 1 in 3 bisexual men and 4 in 10 gay men have experienced some form of sexual violence in their lifetime, compared to 1 in 5 heterosexual men (2010). A major report on LGBT lives in Brighton and Hove, UK (where the present case study was conducted), has also found that bi and trans* people are more likely to experience domestic violence and abuse than heterosexuals, lesbians and gay men (Browne, 2007). There is very limited data on trans* experiences of sexual violence, but the data that is available suggests that trans* people are subject to high rates of harassment and discrimination for their perceived non-conformity. One study estimates that 64% of trans* people have been victims of sexual assault in their lifetime (Grant, Mottet & Tanis, 2011).

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4 There is also limited research on the experience of BME survivors, but help-seeking
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6 behaviour seems to differ by ethnicity, with white female survivors of intimate partner violence
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8 more likely to disclose to a ‘formal’ source (social workers, police, or other professionals) than
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10 women from ethnic minorities (Postmus, 2015). One of the BME communities particularly at
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12 risk of sexual violence in the UK are Gypsy and Traveller women, who face higher rates of
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14 intimate partner violence than the general British population (Cemlyn et al., 2009). Factors
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16 contributing to this risk include highly isolated communities, experiences of racism and
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18 discrimination from outside of the community, and strongly enforced gender roles (2009).
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24 Despite the fact that these communities may be at higher risk of sexual violence, support
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26 services report low uptake from LGBT and BME survivors (Grace, 2014; Harvey, Mitchell,
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28 Keeble, McNaughton Nicholls & Rahim, 2014; Hester et al., 2012; Rape Crisis England). This
29
30 suggests that people from these communities are experiencing barriers to access, but very little
31
32 research has been done to explore them.
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37 The literature on BME survivors of domestic and sexual violence that does exist notes
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39 that viewing barriers to access as ‘internal’ to BME survivors and their communities is harmful;
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41 for example, by blaming cultural taboos and language issues, this shifts responsibility from the
42
43 support service to the survivor (Sokoloff & Dupont, 2005; Thiara, Roy & Ng, 2015). However,
44
45 the literature is contradictory in terms of recommending best practice. Whilst previous studies
46
47 suggest that some BME survivors would prefer service workers of the same ethnicity as them
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49 (e.g. Thiara, Roy & Ng, 2015), others indicate that there are several reasons this might *not* be the
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51 case. For example, in Hester et al.’s 2012 study, several Asian respondents expressed concern
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53 that an Asian service worker may be part of the same community as them, and therefore
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4 potentially 'out' them to friends and family. One thing this literature does agree on is that BME
5
6 survivors tend to want community-led services (e.g. Thiara, Roy & Ng, 2015).
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10 There have been some studies focussing on the experiences of trans* survivors in recent
11
12 years which suggest that trans* survivors more than any other sexual minority face
13
14 discrimination and a lack of services (Harvey et al. 2014; Hester et al. 2012; Rymer & Cartei
15
16 2014). Within the trans* umbrella, trans women in particular have expressed uncertainty over
17
18 how welcome women-only services are to them, and have reported negative experiences when
19
20 attempting to access them (Harvey et al., 2014; Rymer & Cartei, 2014). Additionally, non-binary
21
22 survivors face particular barriers in accessing gender-specific services, which erase them
23
24 completely (Harvey et al., 2014). The literature also indicates that trans* people are at greater
25
26 risk of violence if they are also members of a racial minority (Grant, Mottet & Tanis, 2011),
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28 suggesting that an intersectional approach to sexual violence support would be useful (see
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30 below).
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37 This existing literature therefore highlights some of the barriers these marginalised
38
39 groups face, but few studies have integrating findings from both survivors and professionals who
40
41 work with the LBGT and BME communities. This paper provides new insights into the barriers
42
43 these survivors face as well as suggestions for improving service provision and social work
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45 practice. It draws on case study data from a project conducted in Brighton and Hove, UK, which
46
47 collected questionnaire and interview data from LGBT and BME survivors and professionals
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49 who work with them. Interviewing these professionals in the current study, including those who
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51 do not specialise in sexual violence support, recognises that services for LGBT and BME people
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53 provide an insight into best practice in serving these communities.
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4 Brighton and Hove is a useful case study for a number of reasons. It is home to a number
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6 of specialist LGBT and BME services, as well as specialist services for sexual violence support
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8 such as a Rape Crisis Centre, Sexual Offences Liaison Officers (SOLOs), and a nearby Sexual
9
10 Assault Referral Centre (SARC). It is also one of the few cities for which local statistics on
11
12 LGBT and BME access to support, including sexual violence support, are available. It is hoped
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14 that the insights this study provides can be usefully applied nationally.
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20 Whilst the LGBT and BME population have their own unique barriers and needs, this
21
22 research considered them together for several reasons. Both groups are underserved locally and
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24 nationally (Browne & Lim, 2008; Brighton & Hove City Council, 2013), and this study revealed
25
26 important similarities in the barriers and needs of both groups as well as additional
27
28 vulnerabilities when these identities overlap (i.e. people are both BME and LGBT). Secondly,
29
30 this study aimed to provide a snapshot of how both underserved groups were treated locally in
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32 order to complement literature which has examined these groups separately. This reflects the
33
34 reality of service provision, in which service providers must cater to a number of marginalised
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36 groups at once.
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42 Finally, this study used an intersectional framework in its analysis. Developed by Black
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44 feminists and Women of Colour in order to describe the experiences of sexism and racism which
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46 ‘simultaneously structure’ their experiences (Hill Collins, 2007), intersectionality questions the
47
48 validity of treating racism, sexism and other oppressions separately. The term was coined by
49
50 Kimberlé Crenshaw, who argued:
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55 [I]f a Black woman is harmed because she is in an intersection, her injury could result
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57 from sex discrimination or race discrimination. (...) But it is not always easy to
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59 reconstruct an accident: sometimes the skid marks and the injuries simply indicate that
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4 they occurred simultaneously, frustrating efforts to determine which driver caused the
5
6 harm (Crenshaw, 1989).
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10 Intersectional scholars have used this framework to examine the effect of interlocking
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12 oppressions, and critiqued the second-wave feminist movement for focussing narrowly on gender
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14 at the exclusion of other forms of oppression (hooks 1982; Lorde 2007). This study therefore
15
16 adopted an intersectional framework to examine how different oppressions and identities
17
18 converge on an individual's experience (See: Discussion).
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22 **Brighton and Hove: The LGBT and BME Population**

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25 Brighton and Hove is a city of 273,000 in the county of East Sussex, on the Southeast
26
27 coast of England. Within Brighton and Hove, 20% of residents identified as BME in 2011,
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29 reflecting the national average (Black and Minority Ethnic Community Partnership, 2013). The
30
31 City Council estimates that as many as 15% of people in the city are LGB, significantly higher
32
33 than the national average of 1.1% (Brighton & Hove City Council, 2013; Office for National
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35 Statistics, 2012). There are no national figures available on the size of the trans* community;
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37 estimates vary widely, but it is thought to be less than 1% of the population (Gender Identity
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39 Research and Education Society, 2011; Office for National Statistics, 2009). In comparison,
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41 Brighton and Hove's trans* population has been estimated by one study to be 5% (Browne &
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43 Lim, 2008).
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50 **Accessing Services in Brighton and Hove**

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52 There are many specialist services for BMER and LGBT people in Brighton and Hove,
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54 and these report high levels of engagement. For example, the Terrence Higgins Trust, who
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56 provide HIV testing and care, saw over 10,000 clients in Brighton and Hove in 2014, 83% of
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58 whom were LGB and 27% of whom were BME.³ Similarly, Mankind, a service for male victims
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4 of sexual violence, saw 101 clients in 2014, 26% of whom were gay or bisexual.³ However, both
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6 services saw less than 1% of clients who were trans* in 2014. Other, non-specialist LGBT or
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8 BME services, including drug and alcohol programmes and mental health services, report low
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10 uptake from LGBT and BME communities (Brighton & Hove City Council, 2013; Browne &
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12 Lim, 2008.
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17 In terms of specialist support for survivors of sexual violence and abuse, Brighton and
18
19 Hove's services include Sexual Offences Liaison Officers (SOLO officers), the Survivors'
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21 Network Rape Crisis Centre, Mankind (a charity for male survivors), and a nearby Sexual
22
23 Assault Referral Centre (SARC) a 40 minutes' train journey away. However, statistics show low
24
25 uptake of these services from LGBT and BME people. As of January 2014, across all Survivors'
26
27 Network services, 8% of service users identified as BME, 10% as LGB, and <1% as trans; all of
28
29 these groups are therefore underrepresented (Survivors' Network, 2014). RISE, another local
30
31 charity which offers domestic violence support, in 2013 found that less than 4% of service users
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33 identify as LGBT (RISE, 2013).
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40 Therefore, Brighton and Hove reflects national data on the underrepresentation of these
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42 groups from a variety of services including health services, mental health services, drug and
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44 alcohol programs, as well as sexual violence and domestic violence support services. What is
45
46 missing from current research, and what this study aims to offer, is examples of best practice
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48 from specialist LGBT and BME services which can be applied to sexual violence support
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50 services. Whilst these services may not all specialise in sexual violence support, the
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52 professionals working within them reported that they deal routinely with disclosures and service
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54 users attempting to access other services, as well as being well-versed in best practice for
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4 supporting these communities. They therefore offer useful examples of best practice for sexual
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6 violence support services seeking to improve support for LGBT and BME people.
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10 11 12 **Methods** 13

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15 Two groups were targeted for this study: professionals working within specialist LGBT
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17 and/or BME services in Brighton and Hove, and LGBT and/or BME survivors of sexual violence
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19 living in the city and surrounding areas. In both cases, respondents completed a web-based
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21 questionnaire with a mixture of multiple choice and open-ended questions, and those who gave
22
23 permission subsequently took part in semi-structured interviews. The aim of surveying and
24
25 interviewing professionals was to identify barriers they had witnessed service users encounter in
26
27 accessing sexual violence support (as well as other services, like mental health), and their
28
29 recommendations for best practice. The aim of surveying and interviewing survivors was to
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31 identify their reported barriers in accessing support services, and recommendations for
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33 improving these services.
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39 **Participants** 40

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42 Twenty professionals participated in the online survey. Seven were from BME
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44 organisations or services, Seven were from LGBT organisations or services, and the remainder
45
46 were not BME/LGBT specialist services but worked closely with these communities in some
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48 capacity. Six semi-structured interviews were conducted with professionals who had filled in the
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50 questionnaire, four from BME organisations/services, one from an LGBT service within a
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52 general domestic violence support organisation, and one from a general University-based
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54 service.
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4 Whilst this study did not focus on refugees and asylum seekers as marginalised group,
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6 two professionals who took part worked for refugee and asylum seeker organisations. Much of
7
8 their insights applied to BME survivors in general, but their feedback on the specific issues
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10 refugees and asylum seekers face were included in the data analysis.
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15 Fifteen survivors completed the questionnaire, aged between 18 and 64. Fifty-three point
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17 3 percent of questionnaire respondents identified as lesbian, 40% as queer, 33.3% as bisexual,
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19 and 6.7% as gay. In addition, 26.7% described themselves as trans*. Eighty percent identified as
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21 White (British or Irish), 13% as White (Other), and 7% as Indigenous European/Caucasian. Two
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23 semi-structured interviews were conducted with questionnaire respondents, one of whom
24
25 identified as heterosexual and Asian, another who identified as lesbian and Black
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27 British/Caribbean.
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33 Whilst recruitment of LGBT participants was successful, 80% of questionnaire
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35 respondents identified as White (British or Irish), meaning that BME survivors were not well
36
37 represented in our sample. This could be for a variety of reasons. Initially, the project called its
38
39 volunteers ‘Champions’, which received negative feedback from BME respondents who felt it
40
41 was not clear how the term related to the aims of the project; this may have affected recruitment.
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43 It is also worth noting that despite four of the five researchers attached to the project identifying
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45 as BME, only one was from a Black ethnic background, which may also have affected uptake
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47 from Black survivors.
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52 **Ethics**

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55 The study received ethical approval from the NHS Social Care Research Ethics
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57 Committee (REC code: 15/IEC08/0023). All participants received an information sheet and were
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59 asked to sign a consent form. Their data was stored securely: the web questionnaire was stored
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4 behind a password, as were all audio recordings from interviews. Transcripts were anonymized
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6 and stored behind a password.
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10 Particular care was given in interviewing survivors: although interviewers did not ask
11 directly about participants' experiences of sexual violence, it was understood that the interviews
12 could still be sensitive and potentially upsetting. Participants' information sheets signposted
13 individuals to services they could access if they felt distressed following the interview. During
14 the interview, interviewers prefaced potentially upsetting questions with a reminder that
15 participants should only answer questions they were comfortable with. In addition, researchers
16 put into practice techniques for interviewing sexual violence survivors as recommended by
17 Campbell, Adams, Wasco, Ahrens & Sefl (2010): showing warmth and emotionality; validating
18 participants' experiences and making them feel 'normal' for having emotive reactions; and
19 giving the participant meaningful control over what topics to cover and when to stop the
20 interview.
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37 **Analysis**

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39 All quantitative data (e.g. percentages) reported in the study were calculated from
40 individual questionnaire responses using Google Analytics (for some questions, respondents
41 were allowed to choose multiple answers, and thus the total percentages add up to greater than
42 100%). In addition, the researchers independently analysed open questions from the
43 questionnaire and interview transcripts via thematic analysis before cross-checking. Consistent
44 with this approach, coding categories were not prescribed, but emerged from coding the data
45 iteratively (Starks & Trinidad, 2007).
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57 The study's intersectional framework also informed data analysis, particularly in the
58 qualitative interview phase. This meant that moments in which participants talked about
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4 structural and political barriers to their access were particularly highlighted, as well as the ways
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6 in which professionals talked about these issues (Phipps, 2016).
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10 11 12 13 **Results** 14

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16 Analysis of the questionnaire and interview data revealed important commonalities in
17
18 best practice across LGBT and BME organisations, as well as the types of barriers identified for
19
20 these groups from professionals and survivors. This section is split into two parts: barriers to
21
22 access, and recommendations of improvement and best practice.
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26 **Barriers** 27

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29 Analysis of data from both professionals and survivors highlighted five main barriers: stigma and
30
31 fear; the effect of small/closed communities; cultural barriers and competence; exclusionary
32
33 services; and the effects of being labelled.
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37 *Stigma, fear and wider structural oppression* 38

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40 Survivors reported that feared or experienced stigma related to their sexuality, gender or
41
42 ethnicity prevented access to support. Fifty percent of respondents did not seek help after their
43
44 experience of sexual violence because they feared discrimination based on their sexuality or
45
46 gender identity. Twenty-five percent reported they did seek help but were discriminated against
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48 because of their sexuality or gender identity.
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53 Whilst rape myths are used to dismiss the experiences of survivors of all identities, these
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55 speak to particular concerns for LGBT survivors: societal disregard for same-sex violence, and
56
57 ignorance about LGBT lives (Harvey et al., 2014; Sokoloff & Dupont, 2005). Whilst no
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59 respondents to the questionnaire indicated they feared, or had been, discriminated against
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4 because of their ethnicity, the qualitative responses indicated this was still a relevant concern.
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6 One interviewee described her mistrust of service professionals stretching back to her childhood
7 experiences with social workers:
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11 We were labelled beyond parental control. Never consistency, one social worker to the
12 next. Very patronising. Now looking back at the comments, they were racist. We were
13 called paki. (Interviewee 2, Survivor, Asian, Muslim, cis woman).
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20 Experiencing racism and stereotyping from other service professionals means BME
21 survivors may avoid mainstream support services later on in life. Many professionals
22 demonstrated awareness of this, and the impact that fear of stigma might have on service users.
23 Racism from service workers has been identified in several studies as a concern for BME
24 survivors seeking help, including stereotypes about conflicts between religion and sexuality,
25 issues of language, and stereotypes about immigrants, refugees and asylum seekers (Coventry
26 Rape and Sexual Abuse Centre, 2014; Hester et al., 2012).
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38 The impact of wider structural oppression was also cited by some survivors as a barrier.
39 One questionnaire respondent noted:
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42 As many of my LGBTQAI friends have pointed out, many individuals do not seek help
43 not due to lack of resources, but because they are too depressed to reach out for help in
44 the first place. Creating safe spaces that facilitate action may be of use to these people.
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51 (Questionnaire participant 11, white (Other), queer survivor).
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54 Previous research has noted that marginalized communities do tend to suffer more from
55 mental health issues and substance abuse issues (Brighton and Hove City Council, 2013; Browne
56 & Lim, 2008). Researchers in the US have suggested that the higher PTSD rates amongst
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4 African Americans could be a product of living in a racist society (Williams, 2013). Whilst
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6 survivors of any background are at risk of depression, anxiety and PTSD, it is clear that LGBT
7
8 and BME survivors may have complex responses which are influenced by wider societal
9
10 oppression, and prevent them from accessing support.
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14 *Small/closed communities*

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16 In agreement with previous research in this area (e.g. Harvey et al., 2014), professionals
17
18 explained that whilst for some service users, their tight-knit communities were important sources
19
20 of support, they could also be a barrier to accessing help; the fear of being ‘outed’ as a survivor
21
22 to the whole community could be daunting, especially if the abuser is a member of the same
23
24 small group. Survivors who identify with marginalised groups may also feel pressure to avoid
25
26 inviting scrutiny or negative judgment onto their communities. This is compounded by worries
27
28 of the consequences of inviting Police involvement within communities with negative
29
30 experiences of law enforcement. Whilst this was a concern highlighted by professionals, no
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32 survivors interviewed mentioned this as a barrier.
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39 *Cultural barriers and competence*

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42 Previous research indicates that BME survivors are concerned that workers will not
43
44 necessarily understand the cultural dimensions of their experiences (Coventry Rape and Sexual
45
46 Abuse Centre, 2014; Hester et al., 2012). To overcome such barriers, the professionals in our
47
48 study highlighted the importance of a ‘by and for’ ethos, with members of the community
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50 represented amongst volunteers and staff and BME staff aiding and engaging with the
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52 community.
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4 Specific cultural issues were identified by several professionals, including language and
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6 cultural norms. For example, not all survivors speak or understand English well enough to feel
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8 confident accessing services without obvious interpreting provision, as a professional interpreter
9
10 reported. As well as language issues, one professional, who was Asian and worked with many
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12 Asian women from traditional backgrounds, noted that for the women she worked with, the idea
13
14 of talking about marital rape ‘would be as ridiculous as someone stepping off Mars and say hello
15
16 to [them]. You’d be speaking a completely foreign language to them’.

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18
19 This is not an issue restricted to traditional Asian households, of course. However, the
20
21 professionals all expressed the importance of ‘cultural competence’: knowledge of the varied
22
23 backgrounds and cultures service users might be coming from and the specific issues these
24
25 survivors may have when accessing support.

26 27 *Services are ‘not for me’*

28
29 Many professionals talked about the lack of awareness their service users had of other
30
31 support services. This was not framed as a failure on the part of service users, but as a wider
32
33 problem for services to consider. For example, a professional from an LGBT organization noted
34
35 that the gay men he worked with would never go to a domestic violence service, as they are
36
37 perceived as for heterosexual women only. Other professionals noted that awareness of domestic
38
39 or sexual violence support is not reaching some communities, or are very far down the list of
40
41 survivors’ priorities if they are facing other issues such as insecure housing or poverty. Another
42
43 professional stressed the importance of her organization’s role as ‘bridging’ between services,
44
45 and noted that many BME services will deal routinely with disclosures of sexual and domestic
46
47 violence.

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4 Being excluded from services was a concern cited by many survivors, particularly trans*
5
6 survivors. For example:

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10 I was AFAB (assigned female at birth) and find it distressing to be gendered this way by
11
12 others (as commonly happens to me) (Questionnaire participant 7, white (British or Irish),
13
14 queer and bisexual non-binary survivor).

15
16
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18 When I was raped after I had come out as trans I knew there were very very few places
19
20 that dealt with men who had experienced rape and doubted very much those places had
21
22 had trans training, and didn't want to have to explain what I was or justify myself in order
23
24 to seek help. (Questionnaire participant 12, white (British or Irish), queer, trans man
25
26 survivor).

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30 This echoes findings from Rymer & Cartei (2014) on supporting trans* service users of a
31
32 rape crisis centre. Ninety-one percent of trans* survivors in this study feared their gender identity
33
34 would affect the support they got, citing fear of discrimination and lack of information on trans*-
35
36 friendly services as major barriers.
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39 40 41 **Labelling**

42
43 Whilst specialist BME and LGBT services/professionals were suggested as positive
44
45 elements of sexual violence support (see 'Discussion', below), being labelled as an LGBT or
46
47 BME survivor is a double-edged sword:
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51 There's already, sort of, labels and expectations. I think when that happens in helping
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53 organisations, people are easily shunted into boxes, and therefore they don't get the help
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55 they need, but the help that people think they should have. (Interviewee 9, Survivor,
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57 Black British/Caribbean, lesbian, cis woman)
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4 If people say yes, that's what I want, than we need to make sure that we have it right.
5
6 What I needed was someone who was interested, who cared. Know your audience, don't
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8 patronise me, get an idea, have the know-how experience to assess someone.
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10
11 (Interviewee 2, Survivor, Asian, Muslim, cis woman)
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14
15 These responses highlight the importance of nuanced, evidence-based support for BME
16
17 and LGBT survivors. Both interviewees expressed exasperation at the stereotyping and
18
19 assumptions that underlay some of their experiences of being labelled as LGBT and BME. In
20
21 effect, treating people as individuals rather than part of an acronym is a key concern for LGBT
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23 and BMER survivors, who may be wary of being 'shunted' (in interviewee 9's words) into an
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25 umbrella category.
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33 **Recommendations of improvement and best practice.** 34 35

36 Professionals were asked to describe their 'best practice' in relation to supporting BME and
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38 LGBT service users, and participants were also invited to share what makes a good sexual
39
40 violence support service, and suggest improvements. Their answers provided some suggestions
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42 of solutions to the barriers they had already identified, and could be divided into three themes:
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44 partnerships with other organisations and social justice movements; services being community-
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46 led; and inclusive advertising of services.
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51 ***Partnerships with other organisations and wider movements for social change*** 52

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54 Many respondents viewed sexual violence support services as part of wider movements
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56 for social change. For example, when asked for any final comments about improving access to
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58 services, one questionnaire respondent wrote:
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4 More education surrounding gender, sexuality, and consent in school and for our GPs.

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7 (Questionnaire participant 10, white (British or Irish), lesbian survivor)

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10 Whilst this is perhaps outside of the remit of sexual violence support services, this
11
12 response indicates that organisations like Survivors' Network are thought of in the same way as
13
14 these wider initiatives. This suggests that sexual violence support services are not only seen to be
15
16 important for helping individuals, but as organisations which can advocate for a marginalized
17
18 group of people in wider society.
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23 Professionals were all in agreement that one organization or service cannot be all things
24
25 to all service users. Whilst this does not absolve services of their duty to work at inclusivity and
26
27 accessibility, it does mean that links between services are invaluable for doing this work. This
28
29 was highlighted as especially important for BME survivors. As a professional from a Gypsy and
30
31 Traveller organisation noted, women who have experienced sexual or domestic violence often
32
33 come to her organisation for help with other matters. This supports previous research, which
34
35 indicates BME women are less likely to access formal support for domestic or sexual violence,
36
37 but are more likely than white women to access other services like housing following abuse
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39 (Postmus, 2015). Therefore, partnerships between sexual violence support organisations and
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41 specialist BME services, or more general services such as housing, would be highly beneficial.
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50 ***'By and for' and community-led services***

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52 For some survivors, having the option of specifying the gender or orientation of support
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54 service workers was important. Amongst LGB participants, 10% found it not very important,
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56 40% considered it neither important nor unimportant, and 50% considered it quite or very
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58 important to disclose to a person of the same sexual orientation.
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4 In terms of gender, 82% of all respondents considered it very or quite important to
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6 disclose to a person of the same gender identity. Of these, cisgender women were most likely to
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8 consider this important (100% considered it quite or very important). Seventy-five percent of
9
10 trans* respondents considered it quite or very important.
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15 No BME respondents considered it important to disclose to a person of the same
16
17 ethnicity. Only two BME respondents answered this question, however, and neither opted to give
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19 more information about their answer, so it is difficult to discern why this might be. One possible
20
21 explanation, suggested by previous research, is hesitancy in ‘outing’ oneself to a member of
22
23 one’s own community (Hester et al., 2012).
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28 Many professionals emphasized that an organization serving a particular community
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30 should have solid representation from that community in its workforce, and explained that this
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32 goes beyond tokenism in two ways: a commitment to the principle of ‘nothing about us without
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34 us’, and a practical commitment to being involved with the community in tangible ways. Even the
35
36 more abstract commitment to representation had an aspect of practical importance: professionals
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38 were generally of the opinion that LGBT and BME service users are more likely to access
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40 services if they can see LGBT and BME volunteers or staff members.
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45 ***Inclusive advertising and trans*-friendly services*** 46

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48 One of the issues respondents highlighted was that LGBT and BME survivors may
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50 simply be unaware that sexual violence support services are for them. The term ‘inclusive
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52 advertising’ appeared several times in questionnaire responses, and cross-organisational
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54 advertising was also encouraged. This echoes findings from professionals, who suggested that
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56 meaningful partnerships between organisations would be highly beneficial.
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4 In particular, trans* respondents reported that it was important that services clearly
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6 advertised whether they were women-only or not, and used the right terminology, for example:
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10 Clearly state that trans people including non binary people are welcome. If it's for all
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12 genders, state this. If it's for all genders other than men, say this rather than 'women'.
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14 (Questionnaire respondent 7, white (British or Irish), bisexual and queer non-binary
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16 survivor)
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20 There were also several suggestions for trans*-dedicated services. This seems to reflect
21
22 the limited data available on the high rates of sexual violence and abuse trans* people face in
23
24 comparison to the general population, and the high rates of discrimination trans* people face
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26 from many mainstream services (Grant, Mottet & Tanis, 2011; Rymer & Cartei, 2014).
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30 Discussion

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34 Data from professionals and survivors was strikingly convergent on most issues. Both
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36 professionals and survivors agreed that stigma and stereotyping occurs in both mainstream and
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38 specialist services. Results from LGBT survivors and professionals echoed the findings of other
39
40 researchers: that same-sex violence is often dismissed, survivors fear being outed, and trans*
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42 survivors in particular face discrimination and lack of services (Harvey et al. 2014; Hester et al.
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44 2012; Rymer & Cartei 2014). It is also important to note in addition to this that previous research
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46 indicates trans* people are at further risk of violence if they are also members of a racial
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48 minority (Grant, Mottet & Tanis, 2011).
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54 Some professionals saw their organisations as places where service users could escape
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56 this type of treatment. However, services cannot be all things to all people, and the survivors'
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58 responses highlighted that it was important for professionals to be aware of the intersections of
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4 identities and experiences their service users may have. For example, a specialist LGBT service
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6 should be as proactive about dealing with racism as it is about homo-, bi- and transphobia. This
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8 suggests that intersectionality is a useful framework for sexual violence support services to use in
9
10 their service provision. Both survivors and professionals suggested that increased collaboration
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12 between different specialist organisations would be beneficial, but an intersectional framework
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14 would require not only collaboration, but work *within* organisations to ensure, for example, work
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16 on LGBT issues is not simply outsourced to LGBT organisations, but is treated holistically by all
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18 organisations alongside other marginalised identities.
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24 An example of an area where an intersectional approach may be useful is the issue of
25
26 language and cultural barriers. The issues survivors reported went beyond translation, but applied
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28 to the words or discourses services employ. For example, one professional who was Asian and
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30 worked with many Asian women from traditional backgrounds had this to say about Survivors'
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32 Network's (the local Rape Crisis Centre) website:
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37 Well, I read your website and I liked the word empowerment. That's a very strong,
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39 meaningful word, but why would you give power to someone has never had experience
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41 of it? The concept is brilliant, the word sounds great, but once I walk through that door, I
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43 am me again, I need to go home, the guys will be home soon, take care of the kids. What
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45 you talk about is for you, is for English girls (Interviewee 1, Professional, translation
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47 service).
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52 Her response indicates that she felt the service did not have women like her in mind
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54 when they used the word 'empowerment': what might a South Asian survivor of sexual violence
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56 make of this word coming from an organisation staffed by, and serving, mostly white women?
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58 The word potentially carries traces of neo-colonialism, in that empowerment is often positioned
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4 as something privileged white women can bestow onto under-privileged women (Mohanty,
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6 1984). This issue affects other BME women too: Black women's bodies have historically been
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8 hyper-sexualised, meaning their relationship with empowerment discourse may be very different
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10 to white women's (see, for examples, critiques of the SlutWalk movement like Brison, 2011). An
11
12 intersectional analysis would, therefore, suggest that race and cultural differences were not
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14 considered alongside gender and the importance of female empowerment when support services
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16 chose what language to employ.
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22 Another way in which survivors differed from professionals was the way in which they
23
24 conceptualised structural oppression. Professionals seemed very much aware of the structural
25
26 barriers their service users – and themselves, in many cases – experienced. On an interpersonal
27
28 level, they suggested that services led by and for marginalised communities were important so
29
30 that service users could get help from people who intimately understood their experiences.
31
32 Survivors went further, more explicitly articulating how power and privilege affected their
33
34 experiences of seeking support on both an interpersonal and structural level. For example, many
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36 survivors agreed they wanted the option of support from someone of their community
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38 (interpersonal), but also explicitly linked the work of sexual violence support services to wider
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40 movements for social justice (structural).
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47 Whilst the professionals who took part in this study were aware of the structural
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49 oppressions survivors might face, their focus on the interpersonal in their approach is potentially
50
51 problematic. The literature on BME survivors of domestic and sexual violence notes that one
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53 danger of focussing on the interpersonal is viewing barriers to access as 'internal' to BME
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55 survivors and their communities, for example blaming cultural taboos and language issues
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57 (Sokoloff & Dupont, 2005; Thiara, Roy & Ng, 2015). This risks leaving structural barriers, like
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4 racism, unacknowledged. The data from this study reinforces the recommendation of Sokoloff &
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6 Dupont (2005), who argue in relation to domestic violence:
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10 In short, although culture is crucial to understanding and combating domestic violence,
11
12 we cannot rest on simplistic notions of culture. Rather, we must address how different
13
14 communities' cultural experiences of violence are mediated through structural forms of
15
16 oppression, such as racism, colonialism, economic exploitation, heterosexism, and the
17
18 like (p. 45).
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22 Once again, an intersectional framework is useful in this regard, because it questions the
23
24 sometimes assumed universality of survivors' experiences whilst attending closely to the role of
25
26 structural oppression as well as culture in producing these differing experiences.
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30 Previous research has suggested survivors want community-led services (e.g. Thiara, Roy
31
32 & Ng, 2015); interestingly, survivors of all identities did not explicitly talk about this in the
33
34 current study. In particular, there was no suggestion from our data that BME survivors would
35
36 find BME-led support services useful. Whilst previous studies suggest that some BME survivors
37
38 would prefer service workers of the same ethnicity as them (e.g. Thiara, Roy & Ng, 2015), others
39
40 indicate that there are several reasons this might *not* be the case . One critique that BME
41
42 respondents in this study reported was for the acronym 'BME' itself. This has been highlighted
43
44 in previous research (e.g. Hester et al. 2012): the umbrella is so wide that it can gloss over the
45
46 vast differences between ethnic groups. Therefore, there is not necessarily any benefit for
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48 survivors to access 'BME-led' services, when their needs and experiences might be hugely
49
50 varied. Another reason BME-led services may not garner positive responses is the effect of small
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52 communities: for example, in Hester et al.'s 2012 study, several Asian respondents expressed
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54 concern that an Asian service worker may be part of the same community as them, and therefore
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4 potentially 'out' them to friends and family. It should be noted that the low response rate of BME
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6 survivors of this study makes it difficult to speculate further. However, there is clearly space for
7
8 further research into the usefulness of the 'BME' acronym and in particular how it affects the
9
10 experiences of survivors seeking support.
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15 Trans*-inclusivity was one issue which it was suggested sexual violence support services
16
17 could improve. Survivors noted numerous ways in which services are failing to make it clear
18
19 whether or how they support trans* survivors, from the way they advertise to the assumptions
20
21 staff make about them. Trans women in other research have also expressed uncertainty over how
22
23 welcome women-only services are to trans women, and have reported negative experiences when
24
25 attempting to access them (Harvey et al., 2014; Rymer & Cartei, 2014). Non-binary survivors
26
27 face particular barriers in accessing gender-specific services, which erase them completely
28
29 (Harvey et al., 2014). Whilst the literature does not suggest that trans men experienced the same
30
31 difficulties in accessing men's services as trans women may experience accessing women's
32
33 services, it has been noted that some trans men may feel unsafe in male-only spaces, particularly
34
35 if they have experienced abuse from a man (Harvey et al., 2014). The overwhelming suggestion
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37 from trans* respondents in this study was that trans*-specific services should be developed in
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39 order to ameliorate these difficulties.
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47 Finally, our data contains no responses from refugee or asylum seeker survivors, so the
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49 results only reflect the views of professionals who work with them. The professionals' responses
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51 reinforces previous research: supporting refugees and asylum seekers requires sensitivity to fear
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53 of deportation, and to fear of institutional encounters in general. However, including refugees
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55 and asylum seekers in our 'BME' category validated the critique survivors had for the acronym
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57 'BME', as refugees and asylum seeker survivors have vastly different experiences to, for
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4 example, Black British survivors. The Refugee Council in the UK has noted that refugee and
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6 asylum seeker women are more likely than the general population to have experienced sexual
7
8 violence: for example, having experienced rape as a weapon of war (Refugee Council, 2012). In
9
10 addition, after arrival, refugee and asylum seeker women are highly likely to belong to one or
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12 more of the groups that are at higher risk of rape than the UK average, due to their often
13
14 precarious living situations, living in poverty, or even in destitution (Refugee Council, 2009).
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16 There remains a gap in the literature about how local sexual violence support services can best
17
18 support refugee and asylum seekers survivors which future research should seek to fill.
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25 An intersectional analysis therefore indicates that whilst survivors' and professionals'
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27 responses did converge in many areas, marginalised survivors have incisive critiques of
28
29 institutional practices which should be heeded. The use of language in support services should be
30
31 carefully considered, from how services choose to advertise their gender inclusivity, to which
32
33 discourses services draw on to describe themselves. In particular, the critique of the BME
34
35 acronym counters the argument made at the beginning of this paper that grouping marginalised
36
37 communities together is a useful exercise. Whilst this might be a tool to provide a snapshot of
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39 service provision across the board, it is a somewhat blunt tool. This critique has important
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41 implications for the manner in which both service providers and researchers approach their work.
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Conclusion

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67 The present study provides insights into barriers to sexual violence support for
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69 marginalised survivors, and identifies possible solutions from both survivors and professionals
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71 who work with them. Support services are encouraged to work from an intersectional framework
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73 which acknowledges the complex experiences and identities of each individual survivor, as well
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75 as requiring different types of specialist organisations to work with each other to strengthen their

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4 best practice. Our findings also demonstrate that whilst interventions like staff training and
5
6 promotion of cultural competence is crucial, equally crucial is a healthy scepticism for
7
8 generalisations about LGBT and BME survivors. A key concern of survivors is the act of being
9
10 labelled and not listened to as an individual with complex needs.
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15 Fruitful avenues of future research indicated by this case study include further
16
17 exploration of the effects of institutional acronyms like ‘LGBT’ and ‘BME’ on the actual
18
19 provision of services. Previous research, for example Thiara, Roy & Ng (2015) has highlighted
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21 some of the problems with grouping diverse ethnic groups together in sexual violence provision,
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23 but there are clearly wider implications for this in a variety of support service settings.
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28 Additionally, further research might be done to discover how far sexual violence support
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30 workers agree with survivors’ conceptualisation of them as part of wider social justice
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32 movements. Exploring how professionals might position their work within LGBT, anti-racist and
33
34 pro-refugee movements could provide useful examples of how organisations with differing
35
36 purviews can work together within a similar framework. This is particularly important given the
37
38 repeated observation by professionals in this study that survivors may not turn first to sexual
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40 violence support services, but may come to their services for help with housing, addiction or
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42 mental health which it later transpires are all issues relating to intimate partner violence. Cross-
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44 organisation communication and support is therefore clearly a useful endeavour.
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51 Finally, specialist services to LGBT and BME survivors of sexual violence should be
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53 embedded in these communities to build trust and awareness of sexual violence support, but
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55 involvement from these communities must be meaningful. This might include a ‘by and for’
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57 ethos, but also a careful consideration of how a service might be useful to marginalised
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59 communities beyond merely being present. Examples include hosting events, or fostering
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connections between communities and other organisations through initiatives like training swaps, and setting up services that run in partnership.

Whilst our findings are limited in sample size and geographical reach, they nevertheless provide an example of local services pooling resources and knowledge to improve their services, something which can be emulated elsewhere. It is clear that LGBT and BME survivors and the professionals who work with them have important roles to play in shaping and improving sexual violence support services, and the recommendations from this study can be applied to services across the country. Additionally, these findings are of international interest; much of the literature examining the intersection of sexual violence with sexuality and race is based in the US, for example (e.g. Postmus, 2015; Sokoloff & Dupont 2005). These findings are therefore of interest in any national context which includes interlocking oppressions based on gender, race, and sexuality.

Notes

1. Black and Minority Ethnic is defined as all ethnic groups other than White English / Welsh / Scottish /Northern Irish / British.

2. LGBT stands for lesbian, gay, bisexual and transgender (or trans).

Throughout this paper, the term ‘trans*’ is used to refer to anyone who does not identify with the gender they were assigned at birth. It is an umbrella term is used to to include all transgender identities including non-binary, and gender nonconforming identities. See more at: itspronouncedmetrosexual.com/2012/05/what-does-the-asterisk-in-trans-stand-for/#sthash.7rMZolY5.dpuf.

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4 3. Both the Terrence Higgins Trust and Mankind kindly supplied this information in email
5
6 correspondence with the authors. Other LGBT and BME services were contacted for
7
8 input, but did not or could not supply this information.
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